IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI SOUTHERN DIVISION

STATE OF MISSISSIPPI, *et al.*, *Plaintiffs*, v. XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services, *et al.*, *Defendants*.	Civil Action No. 1:22-cv-00113-HSO-RPM

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE NATIONAL MEDICAL ASSOCIATION AS *AMICI CURIAE*

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INTERESTS OF *AMICI CURIAE*[1]

The American Medical Association ("AMA"), founded in 1847, is the largest professional association of physicians, residents, and medical students in the United States. The National Medical Association ("NMA"), established in 1895, is the nation's largest professional and scientific organization of African American physicians. It represents more than 50,000 African American physicians and their patients. Together, *Amici* have long recognized that health is a foundational element of well-being and have committed to promoting health equity. *Amici* support CMS's definition of "health equity" to mean (among other things) "[t]he attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health."[2] *Amici* have a strong interest in supporting health care regulation and guidance, including anti-racism plans, to address racial inequities in health care and health outcomes evident in medical and social science data. *Amici* are uniquely qualified by their expertise and perspective as large membership organizations to present the views of the professional health care community and the relevant medical and scientific data to this Court regarding the incentive for anti-racism plans that Plaintiffs challenge in this lawsuit.

INTRODUCTION

In 2015, Congress authorized the Centers for Medicare & Medicaid Services ("CMS") to establish a Merit-based Incentive Payment System ("MIPS") that scores providers of health care services to Medicare beneficiaries along several performance measures, including "clinical practice improvement activities." Congress defined such an activity as one that "relevant eligible professional organizations and other relevant stakeholders"—like *Amici*—"identify as improving

[1] No counsel for a party authored this brief in whole or in part, and no entity or person other than *Amici*, their members, and their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

[2] CMS, *Health Equity*, bit.ly/47bGQOu (modified Oct. 3, 2022); *see also* AMA, *Advancing Health Equity* 36 (2021).

clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes."[3] Such "improvement activities" are one of four MIPS categories. In 2023, to earn full credit for this category, clinicians need only complete 2 to 4 of 104 available activities. In counting anti-racism plans as one option, CMS acknowledged the need to move beyond simply documenting racial disparities and address root causes. Plaintiffs' challenge to that decision rests on their notion that anti-racism plans "encourage[] doctors to see patients not as individuals but as sub-components of racial groups" and "to elevate faddish theories about race above patient care." Am. Compl. [28] ¶ 6. The experience of *Amici* and the scientific literature refute that notion and support CMS's decision.

Although race is well understood as a social construct distinct from ethnicity, genetic ancestry, or biology, there is public health consensus that longstanding systemic and social factors have led to disproportionately adverse health outcomes, including severe illness and death, among individuals identifying with historically minoritized and marginalized races and ethnicities, including Black, Native American, Indigenous, Latino, Asian American, Pacific Islander American, and others identifying as people of color. The medical and public health community widely recognizes the health harms of racism, including clinical care quality inequities for minoritized and marginalized individuals, and the efficacy of anti-racism plans to close gaps and improve clinical practice and health outcomes for *all* individuals.

ARGUMENT

I. *AMICI* PROMOTE ANTI-RACISM PLANS IN ORDER TO IMPROVE CLINICAL PRACTICE AND HEALTH OUTCOMES FOR ALL AMERICANS

Plaintiffs' suit is premised on the view that anti-racism is itself discriminatory. In equating anti-racism plans with racial discrimination, Plaintiffs rely on quotations taken out of context from

[3] 42 U.S.C. § 1395w-4(q)(2)(C)(v)(III).

the work of one author (Ibram X. Kendi, Ph.D.) that "[t]he only remedy to past discrimination is present discrimination" and that such discrimination is acceptable so long as it is "antiracist" and "promotes 'equity.'" Am. Compl. [28] ¶ 2. But Plaintiffs set up a false equivalence between race-based policies that benefit one group and deprive another, and race-conscious policies that aim to address this historical injustice by restoring or creating equal opportunity or access for all. Plaintiffs also claim that the AMA in particular "is pushing clinicians to adopt anti-racism plans" to maximize MIPS compensation. *Id.* ¶ 56. *Amici* are compelled to correct Plaintiffs' mischaracterization both of anti-racism plans generally and of *Amici*'s own position.

Amici define anti-racism as "[t]he active process of naming and confronting racism by changing systems, organizational structures, policies and practices and attitudes, so that power is [fairly distributed] and shared equitably."[4] In medicine, changing systems is a hallmark of quality improvement and patient safety,[5] and addressing power relations has been enshrined in "shared decision-making" since the 1980s,[6] to improve quality and cost[7] through ethical practice. In *Amici*'s view, an anti-racism plan is one that remedies or prevents past, current, or future harm, whether witting or unwitting. In contrast to Plaintiffs' views, the views of *Amici*—as "relevant eligible professional organizations and other relevant stakeholders"—are what Congress pointed to in defining the term "clinical improvement activities" at issue here.[8] *Amici* recognize that anti-racism plans are widely accepted as effective tools to "improv[e] clinical practice or care delivery," and based on health equity research detailed in Part III, *Amici* agree with CMS that, "when effectively executed," anti-racism plans are "likely to result in improved outcomes."[9] Plaintiffs

4 AMA, *Advancing Health Equity*, *supra* note 2, at 28.
5 Inst. for Healthcare Improvement, *Overview*, bit.ly/44NFvfd (visited Aug. 4, 2023).
6 Allston et al., *Shared Decision-Making Strategies for Best Care*, Inst. of Med. (Sept. 2014).
7 Wennberg et al., *A Randomized Trial of a Telephone Care-Management Strategy*, 363 New Eng. J. Med. 1245, 1249 (2010).
8 42 U.S.C. § 1395w-4(q)(2)(C)(v)(III).
9 *Id.*

may disagree with the need for or use of such plans to improve clinical practice. But the evidence shows, and *Amici* and other relevant professional organizations recognize, that such plans are designed to—and do—improve clinical practice and thus fall well within the "improvement activities" Congress authorized CMS to consider for MIPS purposes.

Amici are committed to improving health care practice in the United States, including addressing inequities disproportionately leading to adverse health outcomes in marginalized populations. The AMA has called for "acknowledging the harm caused by racism and unconscious bias within medical research and health care" and "identifying tactics to counter racism and mitigate its health effects."[10] The NMA has been a leading force in advocating for equity and the elimination of disparities in health care since its founding in 1895, by addressing the health care needs of marginalized populations, increasing the number of minority physicians, and improving the overall health of the Black community. The AMA and NMA have worked together in recent decades on their shared goal of advancing equity in medicine, pursuing joint statements, amicus briefs, educational programming, and other advocacy efforts to improve access to health care, promote diversity in the medical profession, and address social drivers of health. Their Commission to End Health Care Disparities, joined by 37 public health, state, and medical specialty societies and other organizations, is committed to tackling health disparities.[11] Ongoing collaboration offers hope for a more equitable and inclusive health care system for all.

Contrary to Plaintiffs' assertion, *Amici* are not "pushing" (Am. Compl. [28] ¶ 56) or otherwise coercing medical practitioners to adopt anti-racism plans, but rather providing evidence-based recommendations. To that end, *Amici* encourage clinicians to *voluntarily* create and

[10] AMA, Press Release, *New AMA Policy Recognizes Racism as a Public Health Threat* (Nov. 16, 2020), bit.ly/3OB8BZH.

[11] AMA, *The History of African Americans and Organized Medicine*, bit.ly/3Oy8TAd (updated June 9, 2023).

implement anti-racism plans, because such plans have been shown to improve clinical practice and health outcomes broadly in society, and close gaps for minoritized and marginalized populations.

II. MARGINALIZED POPULATIONS ARE AT INCREASED RISK FOR ADVERSE HEALTH OUTCOMES

Plaintiffs ignore an odious reality: Racism is a threat to public health.[12] Racial and ethnic inequities in health outcomes are well documented, and persist "even when access-related factors, such as patients' insurance status and income, are controlled."[13] To better understand these health disparities, Congress commissioned a study by the Institute of Medicine (renamed the National Academy of Medicine in 2015) to "[a]ssess the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care (*e.g.*, ability to pay or insurance coverage)" and "[e]valuate potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels."[14] Building on the 1985 "Heckler" Report of the Secretary's Task Force on Black and Minority Health that brought wide attention to disparities in health outcomes,[15] the Institute of Medicine's findings marked a turning point in awareness among the medical community of the adverse impact of racism on quality of clinical care.

Extensive medical and scientific literature on social drivers of health explains the racial and ethnic inequities in health care in the United States.[16] First, the legacy of this country's long

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[12] Jones, 2020 Bray Health Leadership Lecture, *Racism is a Public Health Crisis: Now That We See, What Do We Do?* (Oct. 5, 2020), bit.ly/3YeOKCP; CDC, *Media Statement from CDC Director Rochelle P. Walensky, MD, MPH, on Racism and Health* (Apr. 8, 2021), bit.ly/3rVB1V2.

[13] Inst. of Med., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 1 (Smedley et al. eds., 2003) ("*Unequal Treatment*"); *see also* Hill, *Inequality and African-American Health* 11, 22 (2016).

[14] *Unequal Treatment*, *supra* note 13, at 1.

[15] Agency for Healthcare Research and Quality, *Chartbook on Health Care for Blacks, Part 2: Trends in Priorities of the Heckler Report*, bit.ly/3Kinrlk (reviewed June 2018).

[16] *See generally* CDC, *Social Determinants of Health: Know What Affects Health*, bit.ly/3IWQXd3 (updated Sept. 30, 2021) (defining "social determinants" of health as "nonmedical factors that influence health outcomes").

history of racist policies—such as segregation and persistent inequities in housing, employment, access to health care, and other life opportunities—has led to adverse health outcomes for racial and ethnic groups marginalized by systems and structures.[17] Second, racism and implicit bias in medicine have resulted in lower quality health care for minoritized and marginalized individuals.[18]

A. The Higher Rates of Adverse Health Outcomes Experienced by Minoritized and Marginalized Individuals Are Tied to Social Drivers of Health, and Are Not Primarily Accounted for by Other Observable Risk Factors

Crucially, inequities in health outcomes for minoritized and marginalized individuals "do not arise from bad individual choices or biological differences between races but the social factors that shape people's lives every day."[19] Numerous social drivers of health have historically prevented people of color, and Black individuals in particular, from having the same opportunities as white individuals to attain good physical health.[20] Studies have linked historical slavery to current health outcomes, with counties that had slavery in 1860 experiencing higher current stroke mortality overall, among both Black and white residents, compared to counties that did not have slavery in 1860.[21] Historical higher density of enslaved populations is connected to current higher stroke mortality[22] and shorter life expectancy[23] among Black residents.

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[17] *See, e.g.*, CDC, *Health Equity Considerations and Racial and Ethnic Minority Groups*, bit.ly/3giQc1z (updated Jan. 25, 2022); Braveman et al., *What is Health Equity?*, Robert Wood Johnson Found. (May 2017); Afifi et al., *'Most At Risk' for COVID19? The Imperative to Expand the Definition from Biological to Social Factors for Equity*, 139 Preventive Med. 106229 (2020).

[18] *See* O'Reilly, *AMA: Racism Is a Threat to Public Health*, Am. Med. Ass'n (Nov. 16, 2020), bit.ly/35xEoGE.

[19] 2 *COVID-19 Policy Playbook* 7 (Burris et al. eds., 2021) ("*COVID-19 Policy Playbook*"); *see also* Paradies, *A Systematic Review of Empirical Research on Self-Reported Racism and Health*, 35 Int'l J. Epidemiology 888, 888 (2006) ("The manifestations of racism … in general ensue from societal systems that produce an unequal distribution of power (and hence resources) in societies based on the notion of 'race', where race is a social rather than a biological construct related to the notion of essentialized innate phenotypical, ancestral, and/or cultural difference.").

[20] CDC, *Health Equity Considerations*, *supra* note 17.

[21] Esenwa et al., *Historical Slavery and Modern-Day Stroke Mortality in the United States Stroke Belt*, 49 Stroke 465, 466 (2018).

[22] *Id*.

[23] Reece, *Slave Past, Modern Lives*, 53 J. Black Studies 677, 693-695 (2022).

Living in a racially segregated community is a prime example of a negative social determinant of health. Greater segregation is connected to lower life expectancy for Black neighborhood residents.[24] Inequitable life conditions, substantially driven by residential segregation, have adverse health impacts. For example, disproportionate concentration of pollution causes more, and more severe, asthma.[25] Concentrated industrial exposures cause disproportionate cancer outcomes.[26] And unsafe water supplies cause disproportionate lead exposures and related health outcomes.[27] Poverty, also concentrated in racially segregated areas,[28] is linked to adverse health outcomes. Child poverty "has a profound effect on … birth weight, infant mortality, language development, chronic illness, environmental exposure, nutrition, and injury[,] … influences genomic function and brain development by exposure to toxic stress," and increases risk "of difficulties with self-regulation and executive function, such as inattention, impulsivity, defiance, and poor peer relationships."[29] Housing in segregated communities is disproportionately poorer quality and more crowded.[30] Racially segregated neighborhoods also have lower quality schools—another factor linked to adverse health outcomes.[31] Segregation has also been linked to later-stage diagnosis of cancers and lower cancer survival rates.[32]

Racial and ethnic inequities in employment opportunities lead to adverse health outcomes, with minoritized and marginalized individuals disproportionately working jobs that pay less,

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[24] Khan et al., *Associations Between Neighborhood-Level Racial Residential Segregation, Socioeconomic Factors, and Life Expectancy in the US*, 4 JAMA Health Forum e231805, at 2 (July 14, 2023).
[25] Martinez et al., *Structural Racism and its Pathways to Asthma and Atopic Dermatitis*, 148 J. Allergy & Clinical Immunology 1112, 1115 (2021).
[26] Batiste, *Being Black Causes Cancer* (forthcoming).
[27] Mizelle, *A Slow-Moving Disaster—The Jackson Water Crisis and the Health Effects of Racism*, 388 New Eng. J. Med. 2212, 2212-2213 (2023).
[28] Massey & Fischer, *How Segregation Concentrates Poverty*, 23 Ethnic & Racial Stud. 670, 671 (2000).
[29] Gitterman et al., *Poverty and Child Health in the United States*, 137 Pediatrics e20160339, at 1-2 (2016).
[30] *Id.*; CDC, *Health Equity Considerations and Racial and Ethnic Minority Groups*, *supra* note 17.
[31] Braveman et al., *What is Health Equity?*, *supra* note 17, at 5.
[32] Williams et al., *Racism and Health*, 40 Ann. Rev. Pub. Health 105, 108 (2019).

leaving less money to spend on health care,[33] and provide no or lesser health insurance,[34] while requiring in-person work in health care, service, and retail occupations as well as longer commutes on public transportation—factors that increased risk of exposure to COVID-19.[35]

Across all social determinants of health, stress is a primary pathway for disparate health outcomes. Chronic stress "degrades physiological systems," resulting in "greater susceptibility to pathogens" and decreased "effectiveness of the immune system and resistance to infections, leading to serious illnesses."[36] Researchers "have documented a direct link between social stress and sickness, with stressful life events predicting illnesses as serious as heart disease."[37] Racism, discrimination, and inequitable living circumstances can cause chronic stress, linked to an array of poor health outcomes through various psychophysiological pathways.[38]

The daily experience of racial and ethnic discrimination is a social determinant of health, with extensive research documenting a direct negative impact on health over time through "weathering" (*i.e.*, "early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization").[39] "Discrimination is not necessarily conscious, intentional or personal; often it is built into

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[33] U.S. Dep't of Labor, Women's Bureau, *Median Annual Earnings by Sex, Race and Hispanic Ethnicity*, bit.ly/3rhy5PX (visited Aug. 4, 2023); *see also* Williams et al., 40 Ann. Rev. Pub. Health at 108 ("In 2016, for every dollar of income that white households received, Hispanics earned 73 cents and blacks earned 61 cents.").

[34] Huberfeld & Watson, *Lessons Learned*, in 2 *COVID-19 Policy Playbook* 89, *supra* note 19, at 90.

[35] Galeo, *Introduction: Politics, Policies, Laws, and Health in a Time of COVID-19*, in 2 *COVID-19 Policy Playbook* 11, *supra* note 19, at 12; Gould & Shierholz, *Not Everybody Can Work from Home*, Economic Policy Inst., Working Economics Blog (Mar. 19, 2020), bit.ly/3Yjkyq8(noting that only 16.2% of Hispanic workers and 19.7% of black workers are able to telework, compared to 30.7% of white workers and 37.0% of Asian workers).

[36] Hill, *Inequality and African-American Health*, *supra* note 13, at 74.

[37] *Id.* at 16.

[38] Williams & Mohammed, *Discrimination and Racial Disparities in Health*, 32 J. Behav. Med. 20, 37 (2009); Harrell et al., *Multiple Pathways Linking Racism to Health Outcomes*, 8 Du Bois Rev. 143, 143 (2011); Hill, *Inequality and African-American Health*, *supra* note 13, at 5.

[39] Geronimus et al., *"Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States*, 96 Am. J. Pub. Health 826, 826 (2006).

institutional policies and practices," but such "unconscious bias in interpersonal interactions is [nevertheless] strong, widespread, and deeply rooted."[40] A review of 138 studies clearly linked racism and adverse health impacts for oppressed racial groups, even after adjusting for confounding factors.[41] Studies found that more than 90% of Black individuals reported having experienced racial discrimination,[42] that exposure to discrimination and segregation during childhood predicts adult inflammation with an effect "considerably more robust than that of traditional health risk factors such as diet, exercise, smoking, and low [socioeconomic status],"[43] and that the adverse health effects of "weathering" persist even when controlling for upward mobility and wealth.[44]

B. Minoritized and Marginalized Individuals Receive Lower Quality Health Care and Reduced Access to Treatments Due to Medical Racism and Bias

Racism against minoritized and marginalized individuals within the health care system also results in adverse health outcomes. In exercising independent judgment to determine the appropriate treatment for individual patients, medical professionals may sometimes need to consider race and ethnicity—as a proxy for racism—alongside other relevant factors.[45]

Health care inequities are "undesirable differences in outcomes or care and are generally not driven by informed differences in expressed patient preference."[46] Numerous studies show that

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[40] Braveman et al., *supra* note 17, at 5.

[41] Paradies, *A Systemic Review*, *supra* note 19, at 895.

[42] Hill, *Inequality and African-American Health*, *supra* note 13, at 16.

[43] Simons et al., *Discrimination, Segregation, and Chronic Inflammation*, 54 Developmental Psych. 1993, 1994 (2018); *see also* Kuzawa & Sweet, *Epigenetics and the Embodiment of Race*, 21 Am. J. Hum. Biology 2, 2 (2009) ("[E]nvironmentally responsive phenotypic plasticity, in combination with … acute and chronic effects of social-environmental exposures," better explains the "persistence of [cardiovascular disease] disparities between members of socially imposed racial categories" than does genetics.).

[44] Geronimus et al., *"Weathering" and Age Patterns*, *supra* note 39, at 829-830.

[45] *See* AMA, Press Release, *supra* note 10.

[46] Bryant, *Racial and Ethnic Inequities in Obstetric and Gynecologic Care and Role of Implicit Biases*, Wolters Kluwer, bit.ly/3Kh9IuV (updated May 18, 2023); *see also* Harris, *Cultural Competence*, 33 J. Health & Hum. Servs. Admin. 2, 4 (2010) (defining health disparities as "differences in treatment experienced in the quality of health care received by racial and/or ethnic minorities even when access to care is equal.").

minoritized and marginalized patients—and Black patients in particular—receive lower quality treatment by health care providers, "even when variations in such factors as insurance status, income, age, co-morbid conditions, and symptom expression are taken into account."[47] Black and other patients of color are less likely than white patients to receive preventive care and routine medical procedures,[48] and Black patients are treated less for pain than white patients.[49] Race-based kidney function adjustments based on false ideas about differences in muscle mass have denied Black people access to dialysis and transplants.[50] Physicians refer white patients to a specialist almost twice as often as Black patients.[51] Although Black patients are three times as likely to develop and twice as likely to die from cardiovascular disease, they are more likely than white patients "to receive older conservative coronary treatments than newer or more expensive therapies [that are] more readily available to white [patients]."[52]

Minoritized and marginalized patients are sometimes denied care due to racially biased algorithms. For example, racial biases in pulse oximeters make Black patients nearly three times as likely as white patients to have undetected low oxygen levels, which can negatively impact treatment for COVID-19.[53] Although Black individuals have more chronic illnesses than white individuals (despite similar risk scores), algorithms have referred healthier white patients to care

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[47] *Unequal Treatment*, *supra*, note 13, at 1, 2-3; *see also* Matthew, *Just Medicine* 35 (2015) ("*Just Medicine*").

[48] *Unequal Treatment*, *supra* note 13, at 123; Wynia et al., *Collecting and Using Race, Ethnicity and Language Data in Ambulatory Settings* 6, Comm'n to End Health Care Disparities (2011); *Just Medicine*, *supra* note 47, at 1.

[49] Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PNAS 4296, 4296 (2016); *Just Medicine*, *supra* note 47, at 61, 95.

[50] Ahmed et al., *Examining the Potential Impact of Race Multiplier Utilization in Estimated Glomerular Filtration Rate Calculation on African-American Care Outcomes*, 36 J. Gen. Intern. Med. 464, 470 (2021).

[51] Hill, *Inequality and African-American Health*, *supra* note 13, at 91.

[52] *Just Medicine*, *supra* note 47, at 57-58.

[53] Sjoding et al., *Correspondence: Racial Bias in Pulse Oximetry Measurement*, 383 New Eng. J. Med. 2477 (2020).

management programs more than less healthy black patients, due to racial biases in data collection.[54] There is racial bias in clinical algorithms physicians use, such as who gets heart surgery or requires kidney treatment. Consequently, Black and, in certain circumstances, Latino patients are less likely to get proper care.[55]

These inequities are widespread. A report from the Commonwealth Fund found deep-seated racial health disparities in all 50 states. Such disparities are nowhere more pronounced than in Mississippi where, for example, Black individuals and American Indian/Alaskan Native individuals are more likely to die early in life from conditions that are treatable with timely access to high quality health care.[56] In Mississippi, Black women experience maternal mortality rates four times higher than white women, and one study shows that 87.5% of these pregnancy-related deaths were preventable.[57] Mississippi also has the nation's highest fetal and infant mortality and pre-term death rates.[58]

The NMA has been responding to inequities in health care throughout its history. Although the reasons for disparate health outcomes are numerous and complex, research shows that health care inequities are due not only to social factors, but also to exposure to racism within the medical system.[59] One study found that 73% of "white medical students and residents … hold beliefs about biological differences between" Black and white people, "many of which are false

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[54] Obermeyer et al., *Dissecting racial bias in an algorithm used to manage the health of populations*, 366 Science 447, 447-448 (2019) ("At a given risk score, Black patients are considerably sicker than White patients, as evidenced by signs of uncontrolled illnesses. Remedying this disparity would increase the percentage of Black patients receiving additional help from 17.7 to 46.5%.").

[55] Vyas et al., *Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms*, 383 New Eng. J. Med. 874 (2020).

[56] Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care—A Scorecard of State Performance* 6 (Nov. 2021).

[57] Mississippi State Dep't of Health, *Mississippi Maternal Mortality Report 2017-2019*, at 20 (Jan. 2023).

[58] Ely & Driscoll, CDC, *Infant Mortality in the United States, 2020: Data From the Period Linked Birth/Infant Death File*, 71 Nat'l Vital Statistics Rep. 1, at 2, 6, (Sept. 29, 2022).

[59] *See, e.g.*, AMA, Press Release, *supra* note 10; Rees, *Racism in Healthcare*, Med. News Today (Sept. 16, 2020), bit.ly/3okjoK6.

and fantastical in nature, and that these false beliefs are related to racial bias in pain perception."[60] Another study found that among children who visited emergency departments, Black and Latino children were less likely to "have their care needs classified as immediate/emergent" and "experienced significantly longer wait times and overall visits as compared to white [children],"[61] and the "difference could not be fully explained by possible confounding factors available in the dataset, such as demographic, socioeconomic, or clinical variables."[62] Additionally, "newborn-physician racial concordance is associated with a significant improvement in mortality for Black infants,"[63] and Black residents have higher life expectancy and lower all-cause mortality in counties where Black physicians make up a greater proportion of the primary care workforce.[64]

Since 2007, research has shown that physicians' implicit bias contributes to racial and ethnic disparities in the use of medical procedures.[65] A study showed that higher scores on the Implicit Association Test—a test that measures implicit bias—decreased physicians' likelihood of treating Black patients with thrombolysis.[66] A systematic review of 15 studies measuring implicit bias and health outcomes confirmed that health care professionals hold the same level of implicit bias against Black, Latino, and dark-skinned people as the general population, and that "implicit bias was significantly related to patient–provider interactions, treatment decisions,

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[60] Hoffman, *supra* note 49, at 4299.

[61] Zhang et al., *Racial and Ethnic Disparities in Emergency Department Care and Health Outcomes Among Children in the United States*, 7 Frontiers in Pediatrics 1, at 1 (Dec. 19, 2019).

[62] *Id.* at 5.

[63] Greenwood et al., *Physician-Patient Racial Concordance and Disparities in Birthing Mortality for Newborns*, 117 PNAS 21194, 21194 (2020).

[64] Snyder et al., *Black Representation in the Primary Care Physician Workforce and its Association with Population Life Expectancy and Mortality Rates in the US*, 6 JAMA Network Open e236687, at 8 (Apr. 14, 2023).

[65] Green et al., *Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 Soc'y of Gen. Internal Med. 1231, 1231 (2007).

[66] *Id.*

treatment adherence, and patient health outcomes."[67] A systematic review of 37 studies confirmed the substantial evidence of "pro-[w]hite or light-skin/anti-Black, Hispanic, American Indian or dark-skin bias among a variety of [health care professionals] across multiple levels of training and disciplines."[68]

Studies show that implicit bias influences behavior more directly than conscious bias.[69] Most health care professionals "are low in explicit and high in implicit" bias.[70] In other words, many health care professionals unconsciously hold negative biases against minoritized and marginalized groups, and these negative biases may cause them to provide—even if entirely unintentionally—a lower quality of care to their minoritized and marginalized patients. Consistent with this evidence, the CDC has identified "potential biases in prescribing practices" as one reason for the observed racial and ethnic disparity in COVID-19 treatment.[71]

III. ANTI-RACISM INITIATIVES ARE ESSENTIAL TO IMPROVING CLINICAL PRACTICE AND HEALTH OUTCOMES FOR ALL PATIENTS

Strategies based on ignoring group differences do not eliminate bias, but making health care professionals aware of their own biases and stereotypes can mitigate bias.[72] High-quality care is equitable care that improves outcomes for everyone while also closing gaps for communities that are minoritized or marginalized by social systems and structures.

A. Anti-Racism Plans Are Widely Accepted Tools for Addressing Health Inequity

Despite the claims made by Plaintiffs, *Amici* do not believe that anti-racism plans constitute

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[67] Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes*, 105 Am. J. Pub. Health e60, e60 (2015).
[68] Maina et al., *A Decade of Studying Implicit Racial/Ethnic Bias in Healthcare Providers Using the Implicit Association Test*, 199 Soc. Sci. & Med. 219, 219 (2018).
[69] *Just Medicine*, *supra* note 47, at 39.
[70] Van Ryn et al., *The Impact of Racism on Clinician Cognition, Behavior, and Clinical Decision Making*, 8 Du Bois Rev. 199, 204 (2011).
[71] Wiltz et al., *Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021*, 71 MMRW 96, 99 (2022).
[72] *Just Medicine*, *supra* note 47, at 66-67, 165, 167.

racism against white individuals, nor do *Amici* encourage or condone racism in any form. Nothing in the design or effect of anti-racism plans promotes racism. Rather, the goal of health equity initiatives, including anti-racism plans, is to ensure fairness in health care.

To that end, anti-racism plans involve strategies that "include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one."[73] Anti-racism actions can come in many forms, including "individual transformation, organizational change, community change, movement-building, anti-discrimination legislation and racial equity policies in health, social, legal, economic and political institutions."[74] In a health care setting, anti-racism plans may involve, for example, "a clinic-wide review of existing tools and policies,"[75] "increas[ing the] capture and accuracy of race/ethnicity data in patient records"[76] or creating "easy-to-understand print . . . in the languages most commonly used by … patient populations (*e.g.*, English, Spanish, and Mandarin)."[77] Institutional anti-racism plans can be comprehensive or specific to a service line or initiative.

Under the CMS rule at issue, providers need only adopt two to four activities, and an anti-racism plan is one of more than 100 improvement activities that providers may choose to adopt, and only one of ten possible activities designed specifically to advance health care equity.[78] Contrary to Plaintiffs' allegations, anti-racism plans and other measures to achieve health equity do not advocate racism. Under the rule, if a provider chooses to adopt an anti-racism plan, that

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[73] 86 Fed. Reg. 64,966, 65,969 (Nov. 19, 2021).

[74] *Id.*

[75] *Id*.

[76] Univ. of Rochester Med. Ctr, *Equity & Anti-Racism Action Plan: FY2021 to FY2025* (Sept. 30, 2022), bit.ly/3Kl53bj.

[77] Oregon Health & Science Univ. Med. Sch., *Diversity, Equity, Inclusion and Anti-Racism Strategic Action Plan 2021 – 2025*, at 14 (2021).

[78] As of 2023, an anti-racism plan is only one of 104 improvement activities recognized as part of the MIPS assessment, which also includes 196 quality measures, 39 measures for promoting interoperability in electronic health record systems, and 25 cost measures. *See* CMS, *Explore Measures & Activities*, bit.ly/478AmA5 (visited Aug. 4, 2023).

"should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines," as well as steps to remedy the "issues and gaps" identified in that review, but those broad outlines permit a variety of tools and strategies to help counteract racism and implicit bias that may otherwise affect clinical practice and decision-making and lead to adverse health outcomes for minoritized and marginalized individuals.[79]

Such anti-racism strategies are already widespread in health care, and many organizations have helped to elaborate frameworks relevant to the development of anti-racism plans in the clinical setting. These organizational frameworks include, among many others:

- **American Hospital Association's Health Equity Roadmap.** A "national initiative to drive improvement in health care outcomes, health equity, diversity and inclusion," the Equity Roadmap identifies six levers of transformation, including culturally appropriate patient care, equitable and inclusive organizational policies, collection and use of data to drive action, diverse representation in leadership and governance, community collaboration for solutions, and systemic and shared accountability.[80]
- **Healing ARC.** Formed by a prominent group of health care professionals, The Healing Arc (Acknowledgment, Redress, and Closure) uses race-conscious interventions to create an environment "[where hospitals and health centers] in Massachusetts treat ALL patients with dignity, respect, and fairness," by "addressing the institutional racism that prevents some, particularly those in communities of color, from receiving equal care."[81]
- **Rise to Health Coalition.** The Coalition is led by the AMA and the Institute for Health Improvement in partnership with several organizations, including the National Committee

[79] 86 Fed. Reg. at 65,969.
[80] Am. Hospital Ass'n Inst. for Diversity and Health Equity, *The Health Equity Roadmap*, bit.ly/4541vlF (visited Aug. 4, 2023).
[81] *The Healing Arc*, bit.ly/44UMgMf (visited Aug. 4, 2023).

> for Quality Assurance responsible for several MIPS quality measures. Focusing its work on four impact areas—access, workforce, social and structural drivers of health, and quality and safety—the Coalition outlines six steps groups can take to advance a vision of equitable health in which "all people have the power, circumstances, and resources to achieve optimal health."[82]

Individual providers have also contributed recognized anti-racism frameworks for training in medicine,[83] as well as teaching anti-racism in the clinical setting.[84]

B. Anti-Racism Plans Advance Equitable Health Care

Amici view commitment to anti-racism as a public good that improves health outcomes for *all* of society and closes gaps. The impact of anti-racism plans is demonstrably positive, with many accreditation agencies, professional societies, public health institutions, and health systems using anti-racism plans to improve clinical practice and health outcomes. For example:

- The Accountability for Cancer Care Through Undoing Racism and Equity (ACCURE) project implemented an anti-racism intervention consisting of training, data tracking, and feedback for providers at health care facilities in Greensboro, North Carolina and Pittsburgh, Pennsylvania. The intervention nearly eliminated the 7-percentage-point gap in treatment completion rates between Black and white patients, improving cancer outcomes for both Black and white patients.[85]
- HealthPartners, a Minnesota-based health care and insurance provider, sent stool sample test kits to patients of color with no history of colon cancer screening, resulting in a 3.5-point increase in screening, reducing the disparity gap in colon cancer

[82] Rise to Health Coalition, *Together, We Can Create Health Care that Cares for All of Us*, bit.ly/3Koug4u (visited Aug. 4, 2023).
[83] Monroe et al., *Antiracism Training in Medicine*, 1 JAMA Health Forum e201477, at 1-2 (Dec. 3, 2020).
[84] Wang et al., *Teaching Anti-Racism in the Clinical Environment*, 136 Am. J. Med. 345, 348-349 (2023).
[85] The Bridgespan Group, *A Case Study in Anti-Racist Organizing* 10-12 (2022).

screening between patients of color and white patients.[86] HealthPartners also created an Equity, Inclusion and Anti-Racism Cabinet to increase equity, improving diversity in its workforce, eliminating gaps in COVID-19 vaccination rates, and making progress in closing gaps in breast cancer screening.[87]

- The Ohio State University's Wexner Medical Center and Health Science Colleges created an Anti-Racism Action Plan, which established anti-racism goals to improve health equity and created action groups to monitor their progress. In Ohio, for example, Black infants are more than 2.8 times more likely to die than white infants.[88] The Plan saw a decrease in infant mortality rates in marginalized neighborhoods, an increase in flu vaccination rates in minoritized communities, and improvement in colorectal cancer screening rates in Black patients.[89]
- A 2020 study of hospitals in California and Florida on their culturally and linguistically appropriate services found that hospitals offering such services experienced shorter lengths of stay than the median length of stay across all surveyed hospitals.[90]

These anti-racist initiatives in health care highlight the opportunities to effectively improve clinical practice and reduce health inequities as intended by Congress and CMS.

CONCLUSION

For the reasons stated above and in Defendants' brief, *Amici* respectfully urge this Court to deny Plaintiffs' motion for summary judgment and grant Defendants' cross-motion.

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[86] HealthPartners, Press Release, *HealthPartners Recognized for Colorectal Cancer Screening Efforts* (Mar. 29, 2018), bit.ly/3OkuECi.

[87] HealthPartners, *Equity, Inclusion and Anti-Racism Report to the Community* 2, 7, 11-12 (2023), bit.ly/3DIozus.

[88] Ohio Dep't of Health, *2019 Infant Mortality Annual Report* 5 (2020).

[89] The Ohio State University Wexner Medical Center and Health Science Colleges, *Health Equity and Anti-Racism Report: HEAR 2021*, at 8, 17, 20-21 (2021).

[90] Schiaffino et al., *Culturally and Linguistically Appropriate Hospital Services Reduce Medicare Length of Stay*, 30 Ethnicity & Disease 603, 603 (2020).

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